March 3, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0438-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed D.O. with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___, a 44-year-old woman, injured her lower back in a work-related accident on ___ when employed by ___. She was a caregiver and was giving a resident a shower when she went to the floor, injuring her lower back.

This patient eventually came under the care of ___.

Initially, the patient was treated with conservative methods to include pain medicine, anti-inflammatory medicine and physical therapy.

Because of her persistent pain, she underwent a MRI that demonstrated a 2 mm disc bulge at L5/S1. She had an EMG/NCS in September of 2000 that demonstrated electrical physiological evidence of a chronic S1 radiculopathy of longstanding duration. This patient has undergone facet joint injections with no long-term relief. She has also undergone a thermal anuloplasty at L5/S1 on September 13, 2001 by ___, without long-

term relief. X-rays of the lumbar spine dated July 20, 2002 demonstrate mild osteophyte lipping along the superior end plate of L4, but were otherwise unremarkable. Ms. Anderson had a bone scan on September 7, 2001 that was essentially unremarkable. There was no uptake in the lumbar region or L1 joints. The patient had a post-discogram CT on July 20, 2001 that was essentially unremarkable. The discogram demonstrated some leakage of omnipaque dye noted at L5/S1 with concordant pain.

In the records provided, ___ stated that the patient has a disc bulge at L5/S1 with concordant pain status post IDET at L5/S1 with no long-term relief. She has had low back pain, SI joint dysfunction and depression. It is noted that the physical examination documented in the record found 5/5 muscle strength in the lower extremities with reflexes intact.

REQUESTED SERVICE

___ has requested an L5/S1 discectomy and fusion with instrumentation and bone grafting.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Based on the records provided, the reviewer finds that the proposed procedure fails to meet the indications for approval. This patient is neurologically intact, with no clinical evidence of a S1 radiculopathy. The EMG/NCS demonstrates a chronic longstanding radiculopathy that is not supported by physical findings. In addition, her MRI is essentially unremarkable with a mild “disc bulge at L5/S1.” There is no evidence of a compressive lesion at that level. The bone scan is negative, thus there is no compelling indication for fusion at L5/S1 because of ongoing lumbar degenerative disease.

In short, there is no objective evidence to support the proposed procedure.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee’s policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 3rd day of March 2003.